health equations INTAKE FORM

Name _____ Date _____

Occupation _____ Age _____ Sex _____ D.O.B. _____

Blood Pressure _____ Pulse _____ Blood Type _____

Please circle words or check boxes for whatever applies to you; fill in blanks.

◆ **Water, Salt, Energy, Stress:**

My current salt use is- *low, moderate, heavy, by taste*

I have never used much or any salt- *True* or *False*

I previously used salt more than now- *True* or *False*

I have followed a low salt diet for _____ years.

Average energy level on a scale of 1 to 10 _____

Number of glasses of water each day _____

I crave salt and/or salty foods- *True* or *False*

I have unquenchable thirst- *True* or *False*

I sweat ... *a-lot, moderately, very little, not-at-all*

Average stress level on a scale of 1 to 10 _____

◆ **Family History:** ❑ cardiovascular disease ❑ adult onset diabetes ❑ thyroid disease ❑ osteoporosis

◆ **Milk Intolerance:** (circle one) **Y N**

◆ **Number of TOTAL pounds lost throughout your life dieting** _____.

◆ **Number of silver/amalgam fillings, currently** _____, **removed** _____.

◆ **Number of root canals, currently** _____, **removed** _____.

◆ **Exposure to heavy metals, chemicals, dust, infections, radiation, plastics:** _____

_____

◆ ***Women Only***

Number of childbirths _____

Number of years nursing _____

Menstrual-related symptoms _____

_____

Perimenopausal years _____

Menopausal years _____

Menopausal symptoms _____

_____

◆ ***Men Only***

Prostate enlargement? **Y N**

Elevated PSA? **Y N**

Urination difficulties? **Y N**

Nighttime urination? **Y N**

Sexual difficulties? **Y N**

FOOD DIARY

Please indicate the NUMBER OF SERVINGS PER WEEK you have of each of the following foods:

beef_____

poultry
white_____
dark_____

lamb_____

fish_____

pork_____

soy "milk"_____

tofu/soy products_____

milk_____ %fat____

yogurt _____ %fat____

cottage cheese____ %fat____

eggs (# per week)_____

butter_____
(sticks per week)

cheese _____
(ounces per week)

fresh fruit _____

fresh vegetables _____

breads, cereals, grains and pastas:
~refined/processed_____
~whole grain _____

legumes_____ seeds _____

nuts/nutbutters _____

oils, *please specify kind(s)* — *weekly servings*

_____ _____

_____ _____

_____ _____

protein powder, *specify kind - weekly*

_____ _____

sweets (cookies, cakes, sodas, candy, ice cream, *etc.*)_____

caffeine: tea_____ coffee_____

dark soda_____ light soda_____

wine_____ beer_____ liquor_____

How much *calcium* do you supplement daily? _____ *mg*
For how long? *(circle one)* weeks, months, years

How much *magnesium* do you supplement daily? _____ *mg*
For how long? *(circle one)* weeks, months, years

EXERCISE

Please describe the type, frequency and duration of exercise.

_____

_____

_____

For Calculation of %BODY FAT

Height _____ Weight _____

Abdomen Measurement at Navel _____ inches

(Women only) Hips Measurement at the Widest Point _____ inches

(Men only) Wrist Measurement _____ inches

DIGESTION INDICATOR CHECKLIST

- ❑ food allergies/intolerances: _____
  _____
- ❑ crave specific foods: _____
  _____
- ❑ avoid specific foods: _____
  _____
- ❑ low fat or no animal fat
- ❑ low or no carbohydrates
- ❑ burning sensation in stomach which eating relieves
- ❑ burping
- ❑ acid indigestion, sour stomach, heartburn
- ❑ tight/full upper abdomen after eating
- ❑ pale stools
- ❑ crave fats
- ❑ gall bladder attacks or stones
- ❑ abdominal bloating / distention
- ❑ flatulence (gas)
- ❑ coated tongue
- ❑ diarrhea
- ❑ constipation / incomplete evacuation
- ❑ alternating diarrhea and constipation
- ❑ loss of taste for meat
- ❑ always hungry
- ❑ low blood sugar ❑ high blood sugar

SLEEP CHECKLIST

Number of hours _____

Sleep quality:

- ❑ poor ❑ good
- ❑ fair ❑ excellent

- ❑ awake during night at _____ a.m.
- ❑ awake rested
- ❑ difficulty falling asleep
- ❑ awake too early
- ❑ frequent snoring
- ❑ another person has witnessed you stop breathing during sleep

PLEASE INCLUDE A LIST OF ALL SUPPLEMENTS AND MEDICATIONS YOU ARE CURRENTLY TAKING. BE SURE TO LIST THE DOSE AND FREQUENCY FOR EACH ONE.

***health equation*^{s}**

HEALTH SURVEY FORM Name _____ Date_____

INSTRUCTIONS: Number the boxes that apply to you with either a 1, 2, or 3 - -
(1) for **MILD** symptoms
(2) for **MODERATE** symptoms
(3) for **SEVERE** symptoms

Leave the box blank if it does not apply to you!

GROUP 1

1 ☐ Acid foods upset
2 ☐ Get chilled, often
3 ☐ "Lump" in throat
4 ☐ Dry mouth-eyes-nose
5 ☐ Pulse speeds after meals
6 ☐ Keyed up–fail to calm
7 ☐ Cuts heal slowly
8 ☐ Gag easily
9 ☐ Unable to relax; startles easily
10 ☐ Extremities cold, clammy
11 ☐ Strong light irritates
12 ☐ Urine amount reduced
13 ☐ Heart pounds after retiring
14 ☐ "Nervous" stomach
15 ☐ Appetite reduced
16 ☐ Cold sweats often
17 ☐ Fever easily raised
18 ☐ Neuralgia-like pains
19 ☐ Staring, blinks little
20 ☐ Sour stomach frequent

GROUP 2

21 ☐ Joint stiffness after arising
22 ☐ Muscle-leg-toe cramps at night
23 ☐ "Butterfly" stomach
24 ☐ Eyes or nose watery
25 ☐ Eyes blink often
26 ☐ Eyelids swollen, puffy
27 ☐ Indigestion soon after meals
28 ☐ Always seems hungry; feels "lightheaded" often
29 ☐ Digestion rapid
30 ☐ Vomiting frequent
31 ☐ Hoarseness frequent
32 ☐ Breathing irregular
33 ☐ Pulse slow; feels "irregular"
34 ☐ Gagging reflex slow
35 ☐ Difficulty swallowing
36 ☐ Constipation, diarrhea alternating
37 ☐ "Slow starter"
38 ☐ Get "chilled" frequently
39 ☐ Perspire easily
40 ☐ Circulation poor, sensitive to cold
41 ☐ Subject to colds, asthma, bronchitis

GROUP 3

42 ☐ Eat when nervous
43 ☐ Excessive appetite
44 ☐ Hungry between meals
45 ☐ Irritable before meals
46 ☐ Get "shaky" if hungry
47 ☐ Fatigue, eating relieves
48 ☐ "Lightheaded" if meals delayed
49 ☐ Heart palpitates if meals missed or delayed
50 ☐ Afternoon headaches
51 ☐ Overeating sweets upsets
52 ☐ Awaken after few hours sleep—hard to get back to sleep
53 ☐ Crave candy or coffee in afternoons
54 ☐ Moods of depression–"blues" or melancholy
55 ☐ Abnormal craving for sweets or snacks

GROUP 4

56 ☐ Hands and feet go to sleep easily, numbness
57 ☐ Sigh frequently, "air hungry"
58 ☐ Aware of "breathing heavily"
59 ☐ High altitude discomfort
60 ☐ Open windows in closed room
61 ☐ Susceptible to colds & fevers
62 ☐ Afternoon "yawner"
63 ☐ Get drowsy often
64 ☐ Swollen ankles, worse at night
65 ☐ Muscle cramps, worse during exercise; get "charley horses"
66 ☐ Shortness of breath on exertion
67 ☐ Dull pain in chest or radiating into left arm, worse on exertion
68 ☐ Bruise easily, "black/blue" spots
69 ☐ Tendency to anemia
70 ☐ Nose bleeds frequent
71 ☐ Noises in head or "ringing in ears"
72 ☐ Tension under breastbone, or feeling of tightness, worse on exertion

GROUP 5

73 ☐ Dizziness
74 ☐ Dry skin
75 ☐ Burning feet
76 ☐ Blurred vision
77 ☐ Itching skin and feet
78 ☐ Excessive falling hair
79 ☐ Frequent skin rashes
80 ☐ Bitter, metallic taste in mouth in mornings
81 ☐ Bowel movements painful or difficult
82 ☐ Worrier, feels insecure
83 ☐ Feeling queasy; headache over eyes
84 ☐ Greasy foods upset
85 ☐ Stools light-colored
86 ☐ Skin peels on foot soles
87 ☐ Pain between shoulder blades
88 ☐ Use laxatives
89 ☐ Stools alternate from soft to watery
90 ☐ History of gallbladder attacks or gallstones
91 ☐ Sneezing attacks
92 ☐ Dreaming, nightmare type bad dreams
93 ☐ Bad breath (halitosis)
94 ☐ Milk products cause distress
95 ☐ Sensitive to hot weather
96 ☐ Burning or itching anus
97 ☐ Crave sweets

GROUP 6

98 ☐ Loss of taste for meat
99 ☐ Lower bowel gas several hours after eating
100 ☐ Burning stomach sensations, eating relieves
101 ☐ Coated tongue
102 ☐ Pass large amounts of foul smelling gas
103 ☐ Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.
104 ☐ Mucus colitis or "irritable bowel"
105 ☐ Gas shortly after eating
106 ☐ Stomach "bloating" after eating

GROUP 7

(A)

107 ☐ Insomnia
108 ☐ Nervousness
109 ☐ Can't gain weight
110 ☐ Intolerance to heat
111 ☐ Highly emotional
112 ☐ Flush easily
113 ☐ Night sweats
114 ☐ Thin, moist skin
115 ☐ Inward trembling
116 ☐ Heart palpitates
117 ☐ Increased appetite without weight gain
118 ☐ Pulse fast at rest
119 ☐ Eyelids and face twitch
120 ☐ Irritable and restless
121 ☐ Can't work under pressure

(B)

122 ☐ Increase in weight
123 ☐ Decrease in appetite
124 ☐ Fatigue easily
125 ☐ Ringing in ears
126 ☐ Sleepy during day
127 ☐ Sensitive to cold
128 ☐ Dry or scaly skin
129 ☐ Constipation
130 ☐ Mental sluggishness
131 ☐ Hair coarse, falls out
132 ☐ Headache upon arising, wears off during day
133 ☐ Slow pulse, below 65
134 ☐ Frequency of urination
135 ☐ Impaired hearing
136 ☐ Reduced initiative

GROUP 7 (continued)

(C)

137 ☐ Failing memory
138 ☐ Low blood pressure
139 ☐ Increased sex drive
140 ☐ Headaches, "splitting or rending" type
141 ☐ Decreased sugar tolerance

(D)

142 ☐ Abnormal thirst
143 ☐ Bloating of abdomen
144 ☐ Weight gain around hips or waist
145 ☐ Sex drive reduced or lacking
146 ☐ Tendency to ulcers, colitis
147 ☐ Increased sugar tolerance
148 ☐ Women: menstrual disorders
149 ☐ Young girls: lack of menstrual function

(E)

150 ☐ Dizziness
151 ☐ Headaches
152 ☐ Hot flashes
153 ☐ Increased blood pressure
154 ☐ Hair growth on face or body (female)
155 ☐ Sugar in urine (not diabetes)
156 ☐ Masculine tendencies (female)

(F)

157 ☐ Weakness, dizziness
158 ☐ Chronic fatigue
159 ☐ Low blood pressure
160 ☐ Nails weak, ridged
161 ☐ Tendency to hives
162 ☐ Arthritic tendencies
163 ☐ Perspiration increases
164 ☐ Bowel disorders
165 ☐ Poor circulation
166 ☐ Swollen ankles
167 ☐ Crave salt
168 ☐ Brown spots or bronzing of skin
169 ☐ Allergies – tendency to asthma
170 ☐ Weakness after colds, influenza
171 ☐ Exhaustion – muscular and nervous
172 ☐ Respiratory disorders

FEMALE ONLY

173 ☐ Very easily fatigued
174 ☐ Premenstrual tension
175 ☐ Painful menses
176 ☐ Depressed feelings before menstruation
177 ☐ Menstruation excessive and prolonged
178 ☐ Painful breasts
179 ☐ Menstruate too frequently
180 ☐ Vaginal discharge
181 ☐ Hysterectomy/ovaries removed
182 ☐ Menopausal hot flashes
183 ☐ Menses scanty or missed
184 ☐ Acne, worse at menses
185 ☐ Depression of long standing

MALE ONLY

186 ☐ Prostate trouble
187 ☐ Urination difficult or dribbling
188 ☐ Night urination frequent
189 ☐ Depression
190 ☐ Pain on inside of legs or heels
191 ☐ Feeling of incomplete bowel evacuation
192 ☐ Lack of energy
193 ☐ Migrating aches and pains
194 ☐ Tire too easily
195 ☐ Avoids activity
196 ☐ Leg nervousness at night
197 ☐ Diminished sex drive

IMPORTANT

Please list below the five main health complaints you have in order of their importance, most important first:

1._____

2._____

3._____

4._____

5._____

health equations

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Health Equations Release Form

I, _____ acknowledge that Health Equations has explained to me that it is not providing medical services to me and that, for any medical concerns, I should consult with my own physician before and/or during my using the services of Health Equations. I understand Health Equations is providing me with nutritional advice and nutritional supplements. I acknowledge that the nutritional services and products provided to me by Health Equations are not pharmaceuticals and are not regulated and/or approved by the Federal Drug Administration. I consent to providing blood to Health Equations that I understand may be used by Health Equations in connection with its providing nutritional advice and supplements to me as well as research undertaken by Health Equations. I understand that Health Equations will begin providing services only upon receipt of the original of this release, signed by me and witnessed.

_____ _____

Witness client/patient

_____

d/o/b